MDR Tracking Number: M5-05-1500-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-18-05.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 1-12-04 through 1-14-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The IRO reviewed office visits, therapeutic activities, therapeutic exercise, manual therapy, hot-cold packs, electrical stimulation, prolonged physical service, muscle testing, ROM measurements and special reports that were denied as "V" from 1-19-04 through 10-29-04.

The established office visits, level IV **were found** to be medically necessary. The remaining office visits, therapeutic activities, therapeutic exercise, manual therapy, hot-cold packs, electrical stimulation, prolonged physical service, muscle testing, ROM measurements and special reports **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. **The amount due the requestor for the medical necessity issues is $191.76.**

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 3-7-05 the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The carrier denied CPT Code 99080-73 on 1-29-04 and 3-30-04, with a V for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. The Medical Review Division has jurisdiction

in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. A referral will be made to Compliance and Practices for this violation. **Recommend reimbursement of $30.00.**

The carrier denied CPT Code 97010 on 5-7-04, 5-12-04, 5-13-04, 5-21-04 and 5-28-04, with a G-Unbundling. The Trailblazer Local Coverage Determination (LCD) states that code 97010 "is a bundled code and considered an integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is included in the allowance for another therapy service/procedure performed." **No reimbursement recommended.**

Regarding CPT code 97010 on 6-7-04: neither party submitted EOB's. The Trailblazer Local Coverage Determination (LCD) states that code 97010 "is a bundled code and considered an integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment will not be made. Payment is included in the allowance for another therapy service/procedure performed." **No reimbursement recommended.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling $221.76 from 1-29-04 through 3-30-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Decision and Order is hereby issued this 13th day of May, 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

May 11, 2005
April 21, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Change of date in "Disputed Services"

Re: Medical Dispute Resolution
MDR #: M5-05-1500-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ___:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-1500-01

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
Correspondence
Office notes 01/29/04 – 03/30/04
Daily progress notes 01/09/04 – 10/29/04

Therapeutic procedure notes 01/12/04 – 03/24/04
FCE 10/19/04
Nerve conduction study 01/06/04
Radiology reports 12/11/03 – 02/20/04
Information provided by Neurosurgeon:
Office notes 01/29/04 – 07/06/04

Clinical History:
This patient is a 32-year-old male who, on ___, injured his left lower back and left leg in a work-related accident. On 11/4/03, he began treatment with a doctor of chiropractic who performed mobilization, and ordered physical therapy and rehabilitation. A lumbar MRI on 12/11/03 revealed an L4-5 central herniation, a right L5-S1 paracentral herniation, and degenerative discs from L4-S1. An NCV/EMG performed on 1/6/04 suggested a left L3 radiculopathy, but a discogram performed on 2/20/04 was essentially negative. The treating doctor of chiropractic referred the patient to a neurosurgeon and an orthopedist, and he continued with chiropractic care and rehabilitation through 2004.

Disputed Services:
Office visits, therapeutic activities & exercises, manual therapy, hot/cold pack therapy, electrical stimulation, prolonged phy. services, muscle testing, ROM measurements and special reports during the period of **01/19/04** through 10/29/04.

Decision:
The reviewer partially disagrees with the determination of the insurance carrier as follows:
Medically Necessary:
Established office visits, level IV (99214) during the period in dispute.
Not Medically Necessary:
All other treatments, therapies, services and reports in dispute during the period in dispute.

Rationale:
In this case, it was reasonable and appropriate for the treating doctor to periodically evaluate and manage this patient's injury. As a result, the level IV office visits were supported as medically necessary. However, nothing in either the diagnosis or the medical records supported the medical necessity for the addition of the one-on-one, face-to-face prolonged services (99354) that were reported on the same patient encounters as the reexaminations. Furthermore, the range of motion testing services (97851), muscle testing services (95831), and the narrative reporting of the reexaminations were all components of the Evaluation and Management (E/M) service already reported for those

dates (99214), per CPT[1]. Therefore, performing them again would have been duplicative, and as such, medically unnecessary.

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (E) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment.

But in this case, in terms of objective or functional improvement, there were two reexamination narratives (dated 1/29/04 and 3/30/04) submitted for review and they revealed an actual worsening in this patient's condition. Specifically, orthopedic testing deteriorated over the 2 month treatment time (Nachlas, Ely's, sitting SLR and Braggard's testing were all negative on 1/29/04 yet were recorded positive on 3/30/04), and the range of motion changes during the same time frame were essentially immaterial (left lumber lateral flexion went from 12 to 16 degrees, right lumbar lateral flexion went from 13 to only 14 degrees, and extension went from only 19 to 23 degrees; and between these two evaluation dates, lumbar flexion *decreased* from 58 to only 53 degrees). Despite this absence of positive response to prior treatment, there was no change in the treatment plan to justify continued treatment and expectation of functional restoration was not reasonable based on prior lack of success.

Expectation of improvement in a patient's condition should also be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains. But, again in this case, the documentation revealed that the patient's subjective symptoms failed to improve (daily notes repeatedly reported his pain scale rating at "7 out of a possible 10" for months on end, with comments including "pain intensity is severe" and "pain has increased since his last visit." In addition, on both reexamination narratives (dated 1/29/04 and 3/30/04)

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[1] *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

submitted for review, the pain was rated at "7/10" for the lower back and at "5/10" for the left leg. On the most basic level, the statutory requirements[2] for medical necessity were not met in this case since the patient did not obtain relief, promotion of recovery was not accomplished, and – since the patient remained off work during this time – there was no enhancement of the employee's ability to return to employment.

Furthermore, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters* [3] Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Since this patient had been treating with the doctor of chiropractic since 11/4/03, a reasonable clinical trial of manual procedures had already been tried and failed by the first date of dispute in issue here (1/12/04). Since no "significant documented improvement" occurred, all services were not supported as medically necessary.

And finally, even if the treating doctor had sufficiently documented that his care was medically necessary and effectively improving the patient's condition, he failed to establish why the therapeutic exercises and activities (97110 and 97530) were still required to be performed one-on-one past 1/12/04, when current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises." [4]

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[2] Texas Labor Code 408.021

[3] Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.

[4] Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.